

Application for License to
Operate a Long-term Care Facility

For Office Use Only
Received 2/9/12
Amount 1920.00

99005571

I. IDENTIFICATION

Name Essex Nursing & Rehabilitation Center
Address 9600 Lamborne Blvd
City/County/Zip Louisville Ky 40272
Telephone number 502-935-7284
Administrator Joseph R. Flatt esx73-admin@essexnursing.com
Date facility operation began at current address 1979
Date facility began operation under current owner 11/1/2011

II. TYPE BEDS

No. beds licensed

No. beds requested

Skilled

Nursing Home

Nursing Facility

Intermediate Care

ICF/MR

Personal Care

128

II. CONTROL (check one in each column)

State

County

City

Private ☒

Profit ☒

Nonprofit

Individual

Partnership

Corporation ☒

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Hanging Rock, LTC, LLC
P.O. Box 6249
Kinston, N.C.

RECEIVED

FEB 09 2012

OFFICE OF INSPECTOR GENERAL

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation Hanging Rock LTC, LLC
Address of corporation P.O. Box 6249 Kinston NC 28504
President or Chairman N. Randy Uzzell
Vice President Raymond J. Baker
Secretary Raymond J. Baker
Treasurer Dianne Johnson

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company
_____	_____
_____	_____
_____	_____

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Robert Pratt

Signature of authorized representative

Administrator

Title

1/30/12

Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)